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Must be Received or Postmarked On or Before May 1, 2009

AWP TRACK 2 SETTLEMENT CLASS 3 CLAIM FORM

OFFICIAL USE ONLY

FOR PAYMENTS MADE OUTSIDE OF MEDICARE PART B

How to Apply for a Payment from the Proposed Settlement

If you would like to submit a claim in the Settlement, complete this form and mail it to the address below.

YOUR CLAIM MUST BE RECEIVED OR POSTMARKED ON OR BEFORE MAY 1, 2009.

Your claim should be mailed to:

AWP Track 2 Settlement Administrator
P.O. Box 951
Minneapolis, MN 55440-0951

Section A: Claimant Identification

Please provide us with the following information related to the individual who was prescribed one or more of the Class Drugs. This person is referred to as the "Claimant."

Claimant's First Name: John

Claimant's Last Name: Pentz

Address: One Highland Road

City: East Stroudsburg

State: PA

Zip Code: 18301

Daytime Telephone Number: 570-421-6255

Section B: Claimant Representative Information

If you are the Claimant, do not complete this section. Complete this section only if you are a representative (such as a spouse, guardian, executor or personal representative) filing this claim on behalf of the Claimant listed above. Please provide YOUR name, relationship to the Claimant, and YOUR contact information in the spaces provided below.

Contact Name: John Pentz

Relationship to Claimant: Son

Address: 2 Clock Tower Place, Suite 260G

City: Maynard

State: MA

Zip Code: 01754

Daytime Telephone Number: 978-461-1548

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Section C: Should I file a Claim Form?

Please answer the following questions in order to determine if the Claimant is eligible for cash from the Proposed Settlement:

1. Were you, or the Claimant that you are filing on behalf of, prescribed any of the drugs listed in Attachment A of the Notice during the period from January 1, 1991 to March 1, 2008? ☒ **Yes** ☐ **No**
2. Did you, or the Claimant that you are filing on behalf of, pay a percentage of the cost of the drug(s)? ☒ **Yes** ☐ **No**

   Note: If you paid a flat co-payment (i.e., your out-of-pocket expense was always the same for every drug, like a $10 or $25 co-pay) you did not pay a percentage of the cost.

If you answered ***No*** to either of the questions above, you are not eligible to receive any benefits from this Proposed Settlement. You may disregard this Notice and Claim Form. If you answered ***Yes*** to both of the questions above, you should fill out Section D, Section E and Section G below.

Section D: Choose a Refund Option – You Have Two Options

Please check ***only one*** of the boxes below in order to choose your refund option:

☐ **Option 1:** I choose the **EASY REFUND** option. I understand that I will receive a payment of up to $35.00 from the Settlement and that I will not be required to provide additional documentation unless requested by the Claims Administrator **AND** you must sign and date the Claim Form in Section G on page 10 and mail it to the Claims Administration at the address indicated on page 10.

☒ **Option 2:** I choose the **FULL REFUND** option. I understand that in order to receive a full refund I must provide one form of proof of a percentage co-payment for each separate Class Drug listed on the charts in Section E for which I am seeking a refund. The list of acceptable forms of proof are listed below in Section F under "Option 2: FULL REFUND." Please include all proof(s) of payment when submitting this Claim Form.

Section E: Drug Purchase Information - Fill out ONLY if you chose Option 2 – FULL REFUND

Instructions for Completing the Out-of-Pocket Expenditures on Class A & B Drugs Chart

In the Out-of-Pocket Expenditures on Class A & B Drug Charts below, please provide the total amount paid (not monthly) by the Claimant, or the amount the Claimant is obligated to pay, for each of the drugs listed during the time periods in the chart.

- Print clearly
- Do not include flat co-payments in the total amounts paid
- Enter the full amount paid, not a monthly amount

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Out-of-Pocket Expenditures on Class A Drugs

Drug Name	Total Amount Paid From ***January 1, 1991*** to ***November 30, 1997***	Total Amount Paid From ***December 1, 1997*** to ***December 31, 2003***	Total Amount Paid From ***January 1, 2004*** to ***March 1, 2008***
Anzemet (injection & tablets)	$	$	$
Aranesp	$	$	$
Epogen	$	$	$ 1142.52
Ferrlecit	$	$	$
InFed	$	$	$
Neulasta	$	$	$
Neupogen	$	$	$

Out-of-Pocket Expenditures on Class B Drugs

Drug Name	Total Amount Paid From ***January 1, 1991*** to ***March 1, 2008***
AccuNeb	$
Acetylcysteine	$
Acyclovir sodium	$
Adenosine	$
Adriamycin PFS/RFS	$
Adrucil	$
Aggrastat	$
Albuterol sulfate	$
Alcohol injection	$
A-methapred	$
Amikacin sulfate	$

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Section F: Proof of Payment – Provide ONLY if you chose Option 2 – FULL REFUND

If you chose Option 2, you must provide proof that you made a percentage co-payment for each of the Class Drugs you are claiming in the charts in Section E above. You only need to provide one form of proof for each of the drugs.

Any one of the following are acceptable as proof of a percentage co-payment for one of the Class Drugs:

(1) A receipt, cancelled check, or credit card statement that shows a payment for one of the drugs (other than a flat co-payment); or

(2) A letter from a doctor saying that he or she prescribed one of the drugs and you paid part of the cost of one of the drugs (other than a flat co-payment) at least once; or

(3) An EOB (explanation of benefits) from your insurer that shows you made or are obligated to make percentage co-payments for the Class Drugs; or

(4) A notarized statement signed by you indicating you paid or are obligated to pay a percentage co-payment for the Class Drugs between January 1, 1991 through March 1, 2008, including the total of all percentage co-payments for the drugs during the time period; or

(5) Records from your pharmacy showing that you made percentage co-payments for the Class Drugs purchased between January 1, 1991 though March 1, 2008.

Section G: Sworn Statement Regarding Payments Made

I declare under penalty of perjury that the information provided here is, to the best of my knowledge, correct. I also declare under penalty of perjury that I paid a percentage co-pay for one or more of the Class Drugs as indicated in this Claim Form at some time during the period from January 1, 1991 through March 1, 2008. If not submitting this for myself, I am authorized to submit this form on behalf of the Claimant identified above. [1]

John J. Reyes

Signature

John J. Reyes

Print Name

4/1/09

Date

Mail all pages of this Claim Form along with proof(s) of payment, if any, to the following address:

AWP Track 2 Settlement Administrator
P.O. Box 951
Minneapolis, MN 55440-0951

Toll-Free Telephone: 1-877-465-8136
www.AWPTrack2Settlement.com

[1] Please note that your signature on this Claim Form indicates that you declare, under penalty of perjury, that you (or someone on whose behalf you are acting) made a percentage co-payment for one or more of the Class Drugs at some time during January 1, 1991 through March 1, 2008. As a result, providing false information on this Claim Form could constitute perjury.

CVS PHARMACY #1309
PATIENT PRESCRIPTION RECORD
01/01/2007 THRU 12/31/2007

PHARMACY NAME: CVS PHARMACY #1309
ADDRESS: 250 S. COURTLAND STREET
CITY, ST, ZIP: E. STROUDSBURG PA 183010000

PATIENT KEY: 00185201
PATIENT NAME: JOHN PENTZ
ADDRESS: HIGHLAND RD
CITY, ST, ZIP: EAST STROUDSBU PA 183010000

TELEPHONE: 570-424-0830
BIRTHDATE: 09/02/1927
SEX: M
RELATIONSHIP: H

RX NUMBER	RFL NUMBER	NDC	DRUG DESCRIPTION	PRESCRIBER NAME	DATE FILLED	RPH INT	QUANT DISP.	TOTAL PRICE	TP #1 PD AMT	TP #2 PD AMT	TP #3 PD AMT	TP #4 PD AMT	PATIENT PD AMT
426578		00185094098	CHOLESTYRAMINE PACKET SAN	PALANGA,NATALE J	07/13/2007	TP	13.99	17.52	11.52				6.00
1st PYR #: 22950			2nd PYR #:		3rd PYR #:				4th PYR #:				
TP1 AUTH #: O9XXF73			TP2 AUTH #:		TP3 AUTH #:				TP4 AUTH #:				
426576		00591554001	METRONIDAZOLE 250 MG TABLETNAT	PALANGA,NATALE J	07/13/2007	TP	21	3.50	.00				3.50
1st PYR #: 22950			2nd PYR #:		3rd PYR #:				4th PYR #:				
TP1 AUTH #: SA9DNH7			TP2 AUTH #:		TP3 AUTH #:				TP4 AUTH #:				
435559		08290309625	B-D TB SYRINGE 26GX3/8" B-D	PIEL CNP,LIZABETH C	08/16/2007	PP	5	1.29					1.29
1st PYR #:			2nd PYR #:		3rd PYR #:				4th PYR #:				
TP1 AUTH #:			TP2 AUTH #:		TP3 AUTH #:				TP4 AUTH #:				
435556		55513082310	EPOGEN 40,000 UNITS/ML	VIALAMG PIEL CNP,LIZABETH C	08/16/2007	PP	1	527.51	395.63				131.88
1st PYR #: 22950			2nd PYR #:		3rd PYR #:				4th PYR #:				
TP1 AUTH #: OSFCQ93			TP2 AUTH #:		TP3 AUTH #:				TP4 AUTH #:				
437522		08290309625	B-D TB SYRINGE 26GX3/8" B-D	PIEL CNP,LIZABETH C	08/23/2007	PP	2	.59					.39
1st PYR #:			2nd PYR #:		3rd PYR #:				4th PYR #:				
TP1 AUTH #:			TP2 AUTH #:		TP3 AUTH #:				TP4 AUTH #:				
435558	1	55513082310	EPOGEN 40,000 UNITS/ML	VIALAMG PIEL CNP,LIZABETH C	08/23/2007	PP	1	527.51	395.63				131.88
1st PYR #: 22950			2nd PYR #:		3rd PYR #:				4th PYR #:				
TP1 AUTH #: CQCE8NF			TP2 AUTH #:		TP3 AUTH #:				TP4 AUTH #:				
439039		00555083202	WARFARIN SODIUM 2.5 MG TABLETR	MORRIS,ROBERT B	08/28/2007	AB	60	25.99	19.99				6.00
1st PYR #: 22950			2nd PYR #:		3rd PYR #:				4th PYR #:				
TP1 AUTH #: HR3T5WQ			TP2 AUTH #:		TP3 AUTH #:				TP4 AUTH #:				
435558	2	55513082310	EPOGEN 40,000 UNITS/ML	VIALAMG PIEL CNP,LIZABETH C	08/30/2007	TP	1	527.51	176.26				351.25
1st PYR #: 22950			2nd PYR #:		3rd PYR #:				4th PYR #:				
TP1 AUTH #: S8XF82E			TP2 AUTH #:		TP3 AUTH #:				TP4 AUTH #:				
439743		08290309625	B-D TB SYRINGE 26GX3/8" B-D	PIEL CNP,LIZABETH C	08/30/2007	TP	2	.59					.59
1st PYR #:			2nd PYR #:		3rd PYR #:				4th PYR #:				
TP1 AUTH #:			TP2 AUTH #:		TP3 AUTH #:				TP4 AUTH #:				
440243		00555083302	WARFARIN SODIUM 5 MG TABLETBR	MORRIS,ROBERT B	08/31/2007	PP	30	14.11	.00				14.11
1st PYR #: 22950			2nd PYR #:		3rd PYR #:				4th PYR #:				
TP1 AUTH #: 7QR31HP			TP2 AUTH #:		TP3 AUTH #:				TP4 AUTH #:				
435558	3	55513082310	EPOGEN 40,000 UNITS/ML	VIALAMG PIEL CNP,LIZABETH C	09/06/2007	AB	1	527.51	.00				527.51
1st PYR #: 22950			2nd PYR #:		3rd PYR #:				4th PYR #:				
TP2 AUTH #: CN0D9AC			TP2 AUTH #:		TP3 AUTH #:				TP4 AUTH #:				
441630		08290309625	B-D TB SYRINGE 26GX3/8" B-D	PIEL CNP,LIZABETH C	09/06/2007	AB	1	.29					.29
1st PYR #:			2nd PYR #:		3rd PYR #:				4th PYR #:				
TP1 AUTH #:			TP2 AUTH #:		TP3 AUTH #:				TP4 AUTH #:				
442093		00024420010	DROXAVRAL 10 MG TABLET SAN	MOYER,JAMES E	09/07/2007	PP	60	146.84	.00				146.84
1st PYR #: 22950			2nd PYR #:		3rd PYR #:				4th PYR #:				
TP1 AUTH #: HTKRXM1			TP2 AUTH #:		TP3 AUTH #:				TP4 AUTH #:				
442115		00143114205	DOXYCYCLINE HYCLATE 100 MG WSW	MALLORY,TERRENCE R	09/07/2007	PP	6	2.73	.00				2.73
1st PYR #: 22950			2nd PYR #:		3rd PYR #:				4th PYR #:				
TP1 AUTH #: MK9CXCA			TP2 AUTH #:		TP3 AUTH #:				TP4 AUTH #:				